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Changes in Cultural Competency of Nurses Caring for Marshallese Islanders Following an Educational Intervention

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Changes in Cultural Competency of Nurses Caring for Marshallese Islanders Following an Educational Intervention

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Abstract

Background: Marshall Islanders are one of the fastest growing migrant populations in the US and Northwest Arkansas. Health disparities and maintenance of strong cultural values and norms may adversely affect the Marshallese participation in the health care system. Evidence shows that cultural competency training can improve the attitudes, knowledge, skills and behaviors of health professionals and has many positive impacts. The Clinical Cultural Competency Questionnaire (CCCQ) is a research-validated tool that can be used to measure perceived cultural competency through many subscale categories.

Objective: The purpose of this study is to implement a cultural awareness educational program and to examine the results of a pretest and posttest survey evaluating the cultural competency of nurses caring for Marshallese patients before and after an educational intervention.

Methods: Data collected in this quasi-experimental study was compared to evaluate the effectiveness of an educational intervention with nurses in a Northwest Arkansas hospital who interact with Marshallese patients. Nurses completed the CCCQ-PRE, watched an educational video on Marshallese cultural concepts and how they relate to healthcare and then completed the CCCQ-POST.

Results: The results indicated that the nurses' average score following the educational intervention was significantly higher than their average rating prior to the intervention. CCCQ subscale results also showed a significant increase in all but one category.

Conclusion: Ideally, this educational video will be able to be implemented at other hospitals and clinics in the Northwest Arkansas area in order to increase cultural competencies and better improve health care for Marshallese and other diverse populations.

Background and Significance

The Republic of the Marshall Islands consists of more than one thousand islands grouped into twenty-nine atolls and five individual islands located about 2,547 miles southwest of Hawaii and 1,864 miles northeast of Papua New Guinea in the North Pacific Ocean (Baxter, 2018). The United States had control of the Republic of the Marshall Islands (RMI) from 1947 to 1986 before the Compact of Free Association (COFA) was signed making the RMI a sovereign nation and sanctioned Marshallese citizens to lawfully reside and work in the United States without a visa or permanent resident card (Shek, 2011). This tiny country is the smallest of the US-affiliated countries in Micronesia (Baxter, 2018). Even with the high rates of emigration from the Marshall Islands, the country had the fifty-first-highest birth rate in the world in 2017, estimated at 24.4 births per 1,000 residents. However, this rate of population growth raises concern about overwhelming the islands' natural resources. The population of the Marshall Islands is fairly young with 34.89 percent of the population under the age of fourteen and 55.3 percent between the ages of fifteen and fifty-four. In 2017, the life expectancy for RMI males is 71.2 years and 75.7 for females (Baxter, 2018). However, the continual increasing life expectancy statistics of the RMI may likely reflect increased migration to the United States and decrease in the number people who were directly exposed to radiation in the 1940s and 1950s rather than reflecting in improvements of overall health (Duke, 2017). In 2016, the average life expectancy for males in the United States was 76.1 and for females, it is was 81.1 (Kochanek et al. 2017). This data shows that the average life expectancy for Marshall Islanders is lower than that of Americans due to a variety of reasons such as increased health disparities as well as decreased resources and differences in cultural beliefs related to health care.

The Marshallese face significant health disparities in comparison to their American counterparts as well as other immigrant populations. The health problems of Marshallese are often worse than other immigrants; partly due to their ease of legal entry into the US, and a portion of Marshallese migrants (particularly the elderly) come specifically to access the U.S. health care system (Duke 2014). A shift in diet to highly processed foods, sedentary occupations and an increase in Westernization have contributed to the increased frequency of type II diabetes, obesity and cardiovascular disease. The RMI is considered to have some of the highest nuclear contamination in the world after the US made the Marshall Islands the principal site for their nuclear testing program from 1946 to 1958 (Watkins et al. 2006) but it seems that the bodily harm resulting from radiation exposure appears to finally be dissipating with each passing year (Duke, 2017).

Marshallese maintain strong cultural values and norms, which may adversely affect the participation in the health care system of the host society (Choi, 2006). There is a great value placed on interdependency of extended family but the most significant force determining the need for care is their unique cultural concept of time. Marshallese live in the present and do not regularly adhere to ‘clock’ time which creates a disconnect with the healthcare community. Arkansas-based Marshallese tend to seek health care when their symptoms are highly advanced, thus making them and their ailments difficult to treat (Baxter, 2018). Marshallese and English are both official languages of the Marshall Islands and while the majority of the residents speak Marshallese, English is widely spoken as a second language (Baxter, 2018). However, many migrants from the RMI do not speak English well, or at all, which is another major barrier in health care settings (Choi, 2008). Other barriers to health care faced by Marshallese are inadequate transportation, substandard health insurance and the inability to take time off from

work. Another social barrier to accessing health care among Arkansas-based Marshallese is the perceived poor treatment by medical personnel despite health care workers being largely unaware of the discrimination demonstrated in their interactions with the Marshallese (Duke, 2017).

Marshall Islanders are one of the fastest growing migrant populations in the US and Northwest Arkansas, most specifically in Springdale, which has the most dense and fastest growing population of Marshallese residents in the United States (Mcelfish, 2016) facilitated by the economic opportunities provided by the poultry industry (Leonard 2005). The 2010 U.S. Census Bureau states that the Marshallese alone-or-in-any combination population more than tripled in size between 2000 and 2010, increasing from less than 7,000 to more than 22,000 with 1/5 reporting living in Arkansas. Northwest Arkansas has one of the fastest-growing populations in the nation and as of November 2016, the current unemployment rate of Springdale was just 2.6%, and has likewise faced substantial growth in their population. The presence of the Marshallese labor pool, as COFA migrants and neocolonial subjects, has greatly benefited corporations in this region due to their willingness to work for low wages like other immigrant workers and because it allows these companies to avoid legal and human resource hassles associated with hiring employees who may lack requisite legal documentation. The erosion of the RMI's subsistence economy and high rates of unemployment, the lure of these jobs and increased educational opportunities have proven irresistible for Marshallese families explaining why nearly a third of the population of the Marshall Islands has emigrated to the United States (Duke, 2017). According to Raman (2015), improving healthcare professional cultural competency is a key step in reducing health disparities.

Luquis and Perez (2003) define *cultural competence* as the ability of a nurse to acknowledge, understand, respect, and individualize nursing care to a patient's cultural values, attitudes and beliefs. According to the Nursing Code of Ethics (2018), nurses are obligated to provide high quality, compassionate care to all patients, respecting individual dignity regardless of who is receiving the care, or from which nationality, ethnicity, religion, culture, socio-economic class, gender that the patient/client is. An increase in cultural competence allows nurses to provide more efficient, safer care due to better knowledge over possible compliance issues with miscommunication and non-understanding. Evidence shows cultural competency training can improve the attitudes, knowledge, skills and behaviors of health professionals and has a positive impact on patient satisfaction and outcomes (Renzaho et al., 2013; Betancourt and Green, 2010; Beach et al., 2005). Pre-licensure education may inadvertently lead to a belief that learning about different cultures is an end point, but cultural competency is an ongoing process (Utley-Smith, 2017). Data from the 2008 National Survey of Registered Nurses (RN) showed that 83.2% of RNs were non-Hispanic white (Phillips & Malone, 2014) demonstrating that the nursing workforce is far less diverse than the patients they are caring for (Kimbrel, 2018). Even though the RN field is growing in diversity, underrepresentation of nurses from minority backgrounds is a contributing factor to decreased cultural competency in the nursing profession. Following the conclusion of Utley-Smith's research on the use of an online unit of cultural competence education, the graduate level student participants reported intent to continue career-long cultural competence learning and expressed determination to promote cultural competence in organizations where they work and lead. An online quality and culture quiz given to these participants in conjunction with the cultural education assisted students to reflect on their personal and professional cultural competence and encouraged thinking about areas for

improvement. Cultural competence education programs focused on the skills and strategies necessary for addressing language barriers in clinical encounters, or learning specific cultural values about an ethnic group produced positive attitudinal changes among nursing students (Larson, 2010). Since 1986 teaching cultural competence in the delivery of nursing care is an expectation of accreditation and approval boards for schools of nursing (American Association for Colleges of Nursing, 2008; American Nurses Association 1991; Long, 2012; National League for Nurses Accreditation Commission 2005). The Joint Commission is an independent, not-for-profit organization that accredits and certifies nearly 21,000 healthcare organizations and is a nationwide recognized symbol of quality by meeting certain performance standards. The Joint Commission has recognized the importance of having culturally competent nurses caring for diverse patients within the healthcare system and conducted their own qualitative study of 60 hospitals across the country that provide health care to culturally and linguistically diverse patient populations. This study aimed to increase the awareness and competence of nurses caring for diverse patients in order to provide more comprehensive, safer care. It is important to understand nurses' level of cultural competence in order to design education to improve cultural competence awareness, knowledge and comfort.

The Clinical Cultural Competency Questionnaire (CCCQ) is a research-validated tool that can be used to assess cultural awareness, knowledge, desire, encounters and amount of cultural diversity education and will be used in a revised form in this study (Mareno, Hart & VanBrackle, 2013). Nurses perception of personal cultural competence can be compared and analyzed from the results of the CCCQ as well as assess the impact of the intervention implemented through the use of the pretest and posttest. The authors of "Psychometric Validation of the Revised Clinical Cultural Competency Questionnaire" suggested that the

pretest/posttest could be used to evaluate cultural competency training since it has been demonstrated as a reliable measure of cultural competence. For this reason, the CCCQ was used in this study to evaluate the educational intervention created.

The purpose of this study was to 1) develop and implement a cultural awareness educational program and, 2) examine the results of a pre-test and post-test CCCQ survey evaluating the cultural competency of nurses caring for Marshallese patients before and after an educational intervention.

Methods

Overview

This study was conducted following approval from the University of Arkansas Institutional Review Board and the study hospital's Institutional Review Board. The study took place in a Northwest Arkansas freestanding women's hospital.

Design

The design of this quasi-experimental study was to implement and evaluate the benefits of an educational intervention on nurses who interact with Marshallese patients and their families. The intervention was implemented to increase the cultural competency of the nursing staff at a freestanding women's hospital in the Northwest Arkansas area. In this study, a modified version of the Clinical Cultural Competency Questionnaire (CCCQ), created by Dr. Robert Like, was used which measured participants' perceived level of cultural competency through self-evaluation on a Likert-type scale. Permission to use the CCCQ was obtained from Dr. Like in October 2017 by one of the study researchers. The CCCQ-PRE and the CCCQ-POST surveys were accessible online via Survey Monkey as well as printed. Participants gave implied

consent by accessing and completing the surveys. Nursing staff took the CCCQ-PRE test and then were provided a link to an educational video on YouTube, developed utilizing previously published cultural assessment data on the Marshall Islanders in Northwest Arkansas. Along with the literature reviews used to gather the content for the video, three Marshallese women, all of whom had come from the RMI within the past ten years, were interviewed. The interviews elicited the women's views on US healthcare, they're likes and dislikes and what they would want the nurses to know about their culture if they were a patient under that nurse's care. From the literature review and interviews, the video included principal aspects of Marshallese culture such as their history, beliefs, infant feeding, the concept of not having a medical model in the RMI, and additional information potentially impacting healthcare practices in the US related to Marshallese. The video was approximately 9 minutes and created using Powtoon, a cloud-based software for creating animated presentations and animated explainer videos. After the participants watched the video, they took the CCCQ-POST survey which evaluated their perceived cultural competency after the educational intervention. An iPad was provided in the break-room for staff members to complete the surveys and watch the educational video. A link to the pre and post surveys and the educational video was delivered electronically several times through the staff member's hospital email for them to complete on their own time, on several different devices if they chose. Printed surveys were also available for staff members who chose not to complete the study electronically.

Study Population

The sample for the study consisted of nurses and other caregivers who have cared for RMI patients at a Northwest Arkansas Hospital. The sample group served as their own control group comparing the changes from their knowledge prior to and following the educational

intervention. Nursing staff that did not complete both pre and post educational intervention surveys were excluded from the study results (N = 9).

Study Procedures

Pre and post intervention data was reviewed in fall of 2018. The nursing staff who completed the CCCQ were asked to create a four character password with at least one of the characters being a letter. This password documented at the beginning of the pretest and posttest and used as an identifier to compare results of the individual's responses before and after the educational intervention. This identifier was also used to maintain anonymity of respondents to encourage unbiased responses. Demographic data collected included date of birth, sex, nationality, country of origin, ethnic background, if another language other than English could be spoken, function in hospital, highest degree level and the department they work in. Other data collected included socio-cultural knowledge and skills, how comfortable they feel in dealing with cross-cultural encounters, awareness and how much education and training in cultural diversity they have received. The outcome measured is a comparison of the self-perceived cultural competency of nurses following the educational intervention. Cultural competency scores were collected pre-educational intervention and post-educational intervention and then compared.

Timeline

The development of the culturally centered video and surveys were completed on April 10, 2018. The surveys and educational video was accessible by nursing staff at the study site on April 12, 2018. Data collection began on April 12, 2018 and was completed on October 26, 2018. Survey results and trends from the collected data were identified by November 14, 2018.

Statistical Analysis

Thirty nursing staff members completed the pre-test and of those thirty, twenty-one completed both the pretest and posttest meeting the eligibility criteria. The study evaluated a single sample of nurses prior to and after an educational intervention. Hence, each nurse had a score before and after the intervention occurred. Because the study's purpose was to evaluate the effect of the intervention on the nurses' self-perceived cross-cultural competency ratings, a paired *t* test comparing the sample means was the appropriate method to determine if there was a significant difference between pre and post treatment scores. Each nurse was given the CCCQ, a questionnaire with Likert-type items that measured competency in a variety of categories. Each item had listed responses ranging from 1 = Not at all Competent to 5 = Very Competent. When necessary, items included the response 0 = Does not Apply. Any items with 0 were not included in each nurses' final competency score. The final competency score for each nurse is the average score of all answered items. A two-tailed dependent t test was used to determine the significance of the CCCQ subscale data results. There is no post-test education and training section that is comparable to the pre-test section and therefore there is no post-test result to compare.

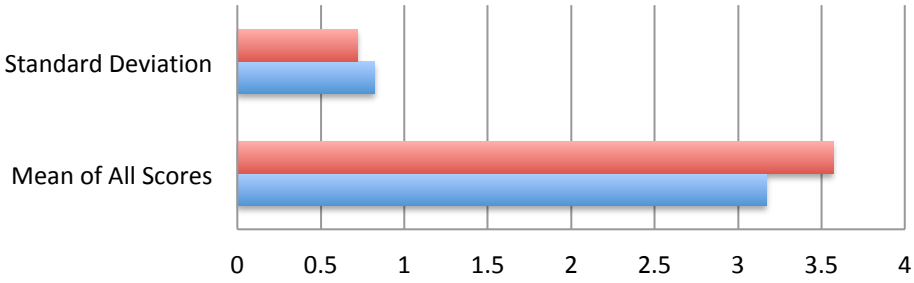
Descriptive Statistics

Demographic information collected from the CCCQ included date of birth, sex, nationality, country of origin, ethnic background, if another language was spoken besides English, function in the hospital, highest degree level if LPN/RN and the department of the hospital that the staff member worked in. Date of birth was categorized by age of less than twenty-five years old (DOB >1992), twenty-six to forty-nine years old (DOB 1968-1991) and more than fifty years old (DOB <1967).

Results

Using an alpha level of .05, a dependent-samples *t* test was conducted to determine whether nurses' self-rated measure of cross-cultural competencies differed significantly following implementation of an educational intervention. The results of the two-tail *t* test indicated that the nurses' average rating following intervention ($M = 3.57$, $SD = 0.72$) was significantly higher than their average rating prior to intervention ($M = 3.17$, $SD = 0.82$), with $t(20) = 4.54$, $p < 0.05$. Figure 1 shows the comparison between the mean of all the nurses' scores and standard deviations for the pretest and posttest. The effect size (Chohen's d) from the

Figure 1- CCCQ Results



	Mean of All Scores	Standard Deviation
Posttest	3.57	0.72
Pretest	3.17	0.82

data collected is d = 0.9904. This large effect size, nearly an entire standard deviation, shows that the difference between pretest and posttest means are meaningful. Using a two-tail, dependent t test to determine the significance of subscale data collected from the CCCQ pretest and posttest results, Table 1 shows the mean score, mean difference and significance for each subscale category. The difference between pretest and posttest results of the subscales *knowledge*, *skills* and *encounters* all prove to be statistically significant while the mean difference of *attitudes* is not statistically significant. Demographic results, while not entirely completed by each participant, show that three participants are under the age of twenty-five; one is fifty or more

years old and twelve state being between ages twenty-five and fifty. All participants were female. All participants stated their nationality as American except for one participant claiming a British nationality and another claiming Hispanic nationality. The two participants claiming non-American nationalities state their countries of origin as England and Mexico respectively. All other participants stated their country of origin as the United States. All participants stated their ethnic background as Caucasian with the exception of one being Hispanic, one being American Indian and one being Native American. Out of twenty-one participants, one claimed speaking another language other than English. Eighteen participants stated their professional role in the hospital was a nurse, two in management and one surgery tech. Fifteen of the participants completed a Bachelor of Science in Nursing and another five completed an Associate's degree in Nursing. Departments that the participants worked in included labor and delivery, management, couplet care, lactation, neonatal intensive care unit and obstetrics.

Subscales	Mean Pretest Score	Mean Post Test	Mean Difference	Significance
Knowledge	2.95	3.38	0.42	0.00006
Skills	2.79	3.41	0.62	0.00033
Encounters	3.02	3.44	0.41	0.00517
Attitudes	4.26	4.29	0.03	0.53827
Education	2.72			

Table 1- CCCQ Subscale Results

Discussion

Research has shown that members of culturally diverse groups rank higher in cultural competence compared to members of the dominant or majority group (Raman, 2015). While the majority of staff members that completed the survey were American Caucasians, four participants claimed different ethnic backgrounds or nationalities. Of these four participants, three participants' average scores on the pretest and posttest were above the mean score of all

participants. Surprisingly, the one participant who stated being able to speak another language other than English scored below the mean scores on both the pretest and posttest. While no causation can be inferred from this small sample size, it does warrant future research into the differences in cultural competencies among majority and minority populations.

Another aspect that, due to small sample size and lack in diversity, cannot be fully evaluated in this study is the differences in male and female self-perceived cultural competency. All twenty-one participants in this study were female and even though male nurses are not as prevalent, a study with more males from the same hospital or another larger hospital might be able to provide statistically significant data of a correlation between sex and self-perceived cultural competency.

Of the twenty-one participants, only four stated being either under twenty-five years old or over fifty years old. All three of these participants' average scores on both the pretest and posttest were above the mean score of all participants. More research to evaluate the effect of age on self-perceived cultural competency would be beneficial.

Even though the sample size is small, the large effect size mentioned in the *results* section shows that the size of the difference between pretest and posttest means is meaningful. All results proved to be significant deeming the educational video used as the intervention to have increased the nurses overall cultural competencies. Of the subscale categories evaluated by the CCCQ, all category means increased from the pretest to the posttest with increasing significance in results of attitudes, encounters, skills and knowledge respectively. Even though the results were significant, a larger sample could be evaluated in the future to have a more in depth understanding of the effectiveness of cultural educational interventions. Hart and Mareno claim that professional continuing education programs are vital to closing the existing gap in

cultural diversity training and that more research is needed to examine the effectiveness of culturally based intervention programs on nurse knowledge, awareness, and skills.

Limitations

There are many factors that contributed to the small sample size of this study. One limitation included the nursing staff's willingness to participate in this study by completing the surveys and education. To increase the interest of staff members to participate, the study researchers used many different strategies. On three separate occasions, cookies were brought to staff with a sign attached asking for nurses to complete the study or thanking those who have already done so. Cookies were also taken to a staff meeting where the study researcher made an announcement detailing the research being conducted, how to participate, where to find the information and to encourage other staff members to complete the study. Flyers were posted to advertise the research around hospital in April when the data collection began. One potential explanation for low staff participation may be due to the fact that there was no incentive to complete the research. The staff was strongly encouraged by management to participate and complete the components of the study in order to comply with Joint Commission cultural competency ongoing education, but no monetary or professional incentives were given.

Lack of awareness of the study and miscommunication among nursing staff also limited the number of participants. The Survey Monkey links to the pretest and posttest as well as the link to the educational video were distributed in mid-April through the hospitals email system to all the staff members. In the email they were put in sequential order as to not confuse staff members along with instructions. However, without an in-person explanation or the chance to ask questions about the instructions or importance of the study, staff members might have been confused on how to complete all the necessary components of the research. During several of the

visits to the hospital, nursing staff on duty were asked by the study researchers if they had completed the research study to which most replied “no” or “I haven’t heard about it”. This leads us to believe that many people were unaware of the previously described actions taken by study researchers to increase awareness of the study. Another study limitation may have been potential subjects not either checking their hospital email account or disregarding the email due to lack of priority in completing the study in comparison to their patient load/stress level at the time.

A major limitation identified was a firewall on the hospital computers was preventing staff members access to the YouTube link to view the educational video. This was an unexpected factor that impacted the number of people who were able to complete the survey in the first few months of its availability. The educational video was downloaded directly onto an iPad in May 2018 following this realization. The iPad was placed in the break room for staff to use after completing the CCCQ-PRE. However, all the links were also sent out in GroupMe (a mobile group messaging app) and were available to access on any smart device.

Originally the data collection period was intended to last six weeks beginning April 12th but due to the numerous technical difficulties and small sample size the data collection period was extended until October 2018. Paper surveys were given to staff in October 2018, in an attempt to overcome this limitation. The paper surveys were identical to the online surveys available to staff. Thirteen responses were collected from the paper surveys in one month.

The last limitation of this study is the generalizability of the results of this study since the sample population came from a single Northwest Arkansas hospital where the research was conducted. The results of this study might not be applicable or represent nurses that care for Marshallese patients in other areas of the United States, Hawaii or the RMI. These results are

also specific to the hospital setting and may not be able to be generalized to other outpatient settings.

Conclusion

These findings suggest that the educational intervention viewed by nurses caring for Marshallese patients in the hospital setting increased nurses self-perceived overall cultural competence. This project was important because it allowed nursing staff to become aware of the gaps in their own cultural competency and increased their knowledge of the Marshallese culture to improve health care for diverse populations. This study encourages the hospital to continue providing cultural education materials to its staff to maintain and increase cultural competency.

If this study were repeated there are several things that could be done differently to yield a better sample size and increase the validity of the results. Paper surveys would be used with no online components due to the large amount of technical difficulties in the original study. Utilizing staff meetings to explain the study fully and have staff complete all parts in one sitting might increase participation. Study researchers could attend several of these meetings until the desired sample size to achieve statistical power is achieved, while also making sure that a new population of nurses is in attendance at each meeting. Incentives such as gift cards could be offered to encourage nurses to complete the entirety of the study. Ideally, this project will be replicated at other hospitals and clinics in the Northwest Arkansas area in order to better improve health care for Marshallese and other diverse populations. Similar studies in other diverse populations should be done to validate the impact of cultural education among healthcare providers.

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